Jaysh Care Services Limited

# Jaysh Care Services

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | **Inadequate** |
| Is the service effective? | **Inadequate** |
| Is the service caring? | **Requires Improvement** |
| Is the service responsive? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service: Jaysh Care Services is a domiciliary care agency that was providing personal care to 11 people at the time of the inspection. The service was supporting very vulnerable people with complex healthcare conditions.

People's experience of using this service:
•People told us they felt safe using the service. However, despite people's positive comments, we found that care was not always delivered safely. People's medicines were not managed safely, risks to people had not been fully assessed and plans to mitigate risks were not in place. Staff had not been trained or assessed as competent to safely meet all the needs of the people they supported. Staff had not been recruited safely and incidents that posed risks to people had not been identified and acted on promptly or appropriately to safeguard people from the risk of abuse.

•The registered manager and company secretary were delivering care due to the shortage of care staff employed. This meant people could not always receive their care at their preferred times but people we spoke with accepted this. Due to these arrangements the registered manager did not have sufficient time to attend to the governance of the service and this had meant ongoing concerns about the quality and safety of the service had not been addressed in a timely manner.

•People's care records were not always person centred, accurate or up to date and the arrangements in place for people's consent to care was not always clear.

•Complaints received had not been investigated or acted on without delay, to prevent a reoccurrence of the failing and mitigate risks to people from unsafe care.

•The registered manager did not have effective systems in place for identifying and managing risks to the quality of the service. This meant that people had been exposed to harm from unsafe care, and that risks to people were ongoing.

•We received positive feedback about the care provided by the registered manager and most of the care staff. People and some people's relatives were appreciative of the flexible approach taken by the service which had enabled them to have the care arrangements they chose.

Rating at last inspection: This was our first inspection of this service which was registered on 12 May 2018.

Why we inspected: This inspection was brought forward in our planned inspection schedule due to information of concern we received from the local authority.

Follow up: A number of breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified during the inspection. The overall rating for this registered provider is 'Inadequate'. This means

that it has been placed into 'Special Measures' by CQC. Services in special measures will be kept under review and, if we have not already taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe, so that there is still a rating of inadequate for any key question or overall, we will act in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded. We will have contact with the provider and registered manager following this report being published to discuss how they will make changes to ensure the service improves their rating to at least Good

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

The service was not safe.

Details are in our Safe findings below.

**Inadequate**

**Is the service effective?**

The service was not effective.

Details are in our Effective findings below.

**Inadequate**

**Is the service caring?**

The service was not always caring

Details are in our Caring findings below.

**Requires Improvement**

**Is the service responsive?**

The service was not responsive.

Details are in our Responsive findings below.

**Inadequate**

**Is the service well-led?**

The service was not well-led.

Details are in our Well-Led findings below.

**Inadequate**

# Jaysh Care Services

**Detailed findings**

## Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the registered manager was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by information of concern from the local authority about the quality and safety of the service provided to people.

Inspection team:
This inspection was carried out by two inspectors.

Service and service type:
Jaysh Care Service is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older adults and younger adults including people living with dementia, a sensory impairment and a physical disability. Not everyone using Jaysh Care Services received the regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. Jaysh Care Services is a single agency provider and the registered care manager is also the provider. We have therefore referred to the provider as the registered manager in this report.

Notice of inspection:

We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 31 January 2019 and ended on 8 February 2019. We visited the office location on 31 January and 5 February 2019 to see the manager and office staff; and to review care records and policies and procedures.

What we did:
Prior to the inspection we reviewed any notifications we had received from the service. A notification is information about important events which the service is required to tell us about by law. We also reviewed any information about the service that we had received from external agencies. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with five people using the service including two people we visited at home; five relatives; a team manager from the local authority adults' health and care team, four care staff; the registered manager and the company secretary. We looked at six people's care records including their daily care records, seven staff files and recruitment records, the training records for all staff, the staffing rota for the period 4 February to 4 March 2019, records of accidents, incidents and complaints, policies and procedures and information relating to improvements planned for the service.

Inadequate

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were not safe and were at risk of avoidable harm. Some regulations were not met.

Using medicines safely

• The provider was not clear about its responsibilities and role in relation to medicines. A medication policy was in place but the guidance this provided was not implemented, or followed by staff. The registered manager told us that people were supported with their medicines by 'prompting' only. This means people are responsible for their own medicines and encouraged or reminded to take them by staff. However, we found people were supported by staff who removed medicines from packaging and provided the medicine to the person. This was the administration of medicines. Information in people's care plans did not clearly and accurately describe the support people received with their medicines. The medication policy in place was not followed in practice and the registered manager lacked an understanding of safe medicine administration.

• A system was not in place to record the administration of people's medicines so they could be monitored safely such as by using a Medicines Administration Record (MAR) in line with NICE (National Institute for health and Clinical Excellence) guidance. This meant people were at risk of the unsafe management of their medicines.

• Care plans did not include full details about the medicines people were supported with or the specific prescriber's directions for each medicine, including those prescribed 'as and when needed' such as some pain relief medicines. This was important to ensure staff administering medicines can check they are giving the right medication and dose at the right time. Staff were supporting some people with their medicines at the direction of people's relatives but had no system in place to confirm they were being administered safely as prescribed.

• Staff completed an on-line training course, supplemented by a module of training on medicines during a training day which covered 13 topics. There was no system in place to check staff were competent in the administration of people's medicines, such as competency assessments. One staff member who was administering medicines to a person told us they could not remember completing any training on medicines other than an on-line session. Staff did not have sufficient knowledge about the administration of people's medicines to ensure they were managed safely. For example, staff did not recognise they were administering medicines to people and were required to keep the records as described above.

• People were supported by staff in the application of topical medicines such as creams and patches applied to the skin. A system was not in place to guide staff as to the frequency of use, the thickness of the application and where on the body the cream should be applied. Records were not kept of creams applied. The registered manager introduced a system to record creams during our inspection but these did not include the prescriber's instructions for the application. Information and guidance was not available on the application of patches and detailed records were not kept of their application.

• The failure to ensure the safe and proper management of people's medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

• Risks to people had not always been assessed, monitored or mitigated effectively. For example, one person's care plan stated that to keep them safe 'Make sure my bed sores are attended to and if there are any changes please tell the district nurse'. There was no risk assessment in place or plan to assist staff to identify any deterioration to this person's pressure sore or how to reduce the risk of any further deterioration or to reduce the risk of the person developing further bed sores. Similarly, we found that other risks associated with people's care such as; catheter care, stoma care, falls, support to eat and drink and moving and handling were not assessed. Whilst staff we spoke with knew about people's care needs there was a lack of guidance for staff on how to manage risks associated with people's needs should they, or staff that did not know the person well, need to rely on this information.

• A person was being supported by care staff with changing dressings on their pressure sore. The registered manager told us they had been delegated this task by the district nurses, and were competent to show other staff how to carry out this procedure. There was no record of the training given to the registered manager or records to show their competency had been assessed and they were competent to train other staff, or that other staff had been assessed as competent. There was no risk assessment in place concerning this wound care. There was no detailed plan in place to guide staff as to the safe management of this person's wounds, such as dressing type and when to change the dressing other than 'if need be', this meant the person could be at risk of unsafe care and treatment.

• Where people were living with specific health conditions that posed risks to them the risks associated with these had not been assessed. For example, one person was at risk of a serious and sudden episode of a health condition. Whilst the usual presence of family carers and the person's ability to tell care staff if they became unwell helped to mitigate the risk. There was no mention of this condition in the person's care plan and no risk assessment to ensure plans were in place to guide staff should this event occur. During our inspection the person's family reminded the registered manager of the person's condition and to add guidance prepared by them to the persons care plan.

• Staff, people and a person's relative told us they were supporting people using moving and handling equipment such as a 'banana board' used to transfer people from bed to chair, and a hoist. Staff had not completed training in the use of this equipment which presented risks to people if not used correctly following a person-centred plan.

• The failure to ensure risks relating to the safety and welfare of people using the service are assessed and managed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse and recruitment

• Safeguarding policies and procedures were in place. Staff completed training in safeguarding people from abuse and told us the types and signs of abuse and how they would act if they were concerned. People and their relatives told us they thought staff would act on safeguarding concerns. However, the registered manager had received a complaint from a person which alleged there was a potential safeguarding incident in November 2018. This should have been raised as a safeguarding in line with legislation. The registered manager was not aware of this and lacked knowledge around their responsibilities in relation to safeguarding.

• The safeguarding policy described the registered manager's commitment to safer recruitment practices, including checks to prevent the risks to people from the employment of unsuitable staff. These had not been carried out for all staff. We reviewed seven staff recruitment records. Not all staff had submitted a full employment history including a written explanation for gaps in employment. Character references were not available for staff recruited. One person employed had previous employment concerned with the provision of care services to vulnerable adults, they had not supplied this information on their application form and information was not available to show why this employment had ended. Some staff had worked prior to a satisfactory Disclosure and Barring Service (DBS) check being received. The DBS carry out checks on

individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions. When a DBS check did show that a person had previous convictions, these were not clearly legible on the information available to the registered manager at the time of our inspection and no risk assessment had been carried out to assess their fitness to work with adults at risk. We were shown a system to obtain up to date DBS checks and this was being implemented at the time of our inspection. There was a risk that unsuitable staff may have been recruited. No information had been recorded about any relevant physical or mental health conditions for staff employed.
• The registered manager used self-employed care staff to provide care and support for one person on a regular basis and another 'as and when needed'. The arrangements in place to employ these staff meant they were subject to the regulations for staffing and the registered manager had failed to obtain all the required information to check they were appropriately and safely employed to support people.
• The registered manager failed to demonstrate the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014 was available for all staff. The registered manager failed to establish and operate effective recruitment procedures to ensure staff were of good character, had the right skills and competence and were physically and mentally fit to perform their role. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing
• The service was operating on limited staff resources, and the registered manager was also delivering a significant amount of care. Not all staff were able to drive and relied on other staff to transport them to their care calls. This meant people could not always receive care at their preferred times. However, people told us they were aware of the limitations of the service in this respect and were satisfied with the current arrangements for their care calls. The registered manager said, "It is definitely difficult to give care at their (people's) preferred times - if something happens you have to stay until something is sorted out. I tell them (people) about my capacity and ask are you happy with that? They know we try and maintain times and no one is not happy at present". A person said, "The timing can be very irregular, I can understand it because of the car (driving) situation, others have to drive as (carer) can't drive yet." There were no missed calls reported. Despite receiving feedback that people understood the staffing issues, the staffing arrangements posed a risk if any staff became unavailable without warning.
• The registered manager told us they were not accepting any new service users until additional staff resources were available. Eight new staff had been recruited who were currently in various stages of the recruitment and induction processes.

Learning lessons when things go wrong
• Safety concerns were not identified or addressed quickly enough. For example, the registered manager told us they had become aware in September 2018 that staff had been unsafely recruited by a person who at the time was running the service. However, we found a system was still not in place to ensure all the required recruitment checks had been made.
• The Local Authority had been working with the registered manager to offer support and guidance following a safeguarding incident in November 2018. However, the registered manager had failed to demonstrate a prompt and sufficient response to improve the safety of the service people received.

Preventing and controlling infection
• All staff had completed some training in infection control and food hygiene. An infection lead was appointed and personal and protective equipment was available and used by staff to prevent and control the risk of infection.

Inadequate

# Is the service effective?

## Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Staff support: induction, training, skills and experience
• The registered manager told us staff new to care completed the Care Certificate. The Care Certificate is a set of standards that sets out the knowledge, skills and behaviours expected of care workers in their role. However, we found the induction training completed by staff did not meet the guidance and standards of the care certificate as outlined by Skills for Care.
• Staff completed a one-day training event which covered 13 topics. E-learning was also available to support some of these standards. Staff at Jaysh Care were awarded their care certificate based on the completion of this training day. The Care Certificate is designed to be tested in practice so that care staff can have their skills assessed and competency checked. Training was also expected to be supplemented by workbooks to check staff knowledge. According to Skills for Care the average time for completion of the care certificate was 12 weeks. The staff training matrix showed staff were signed as having completed the training, knowledge and competency requirements of the Care Certificate during the same one day.
• The aim of the Care Certificate is to ensure staff are competent to provide care prior to working alone. One staff member told us, "The first time (completed training day) no (it was not sufficient training), second time was much better since I had some experience because I now understood it in practice, more helpful once I had the experience". This meant staff new to care may not be competent in their role and this could place people at risk of unsafe care and treatment.
• Staff were supporting people with complex needs, this included the care of pressure sores and wound dressings, stoma care, catheter care, moving and handling using equipment such as transfer boards and a hoist. People they supported were living with spinal cord injuries, Parkinson's disease, a life limiting condition and receiving palliative care, and people at risk of falls. Most staff had not completed training in any of these areas. Three staff members had completed an e-learning module in wound care and two had completed a stroke awareness course. One staff member had completed training in pressure sores. Training was not in place to develop staff knowledge and skills to support the needs of the people they supported.
• New staff worked alongside the registered manager and another carer, who was the company secretary for three to four days as part of their induction. However, there was no competency framework in place to show the registered manager or company secretary had been assessed as competent to show new staff how to deliver care such as wound dressings or moving and handling. Whilst plans were in place to train the company secretary as a moving and handling trainer this had not taken place by the time of our inspection although an incident had occurred in November 2018 of unsafe moving and handling.
• A formal supervision and appraisal system was not in place at the time of our inspection. Staff told us they felt supported by the registered manager and could discuss any concerns with them. However, the lack of a formal supervision system meant that the training, learning and development needs of staff were not reviewed or planned. For example, although one staff member had been identified as requiring further

training and competency in delivering care there was no plan in place to show how these improvements would be achieved and monitored. The registered manager said they would be introducing a system soon.
• A failure to ensure staff were suitably trained, competent, skilled and supported to enable them to carry out their role and meet the needs of the people they supported was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
• The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.
• The registered manager had a mental capacity and DoLS (Deprivation of Liberty Safeguards) policy in place. The policy stated 'Where the service has information that suggests the person might be unable to take some decisions at sometimes, it will carry out an assessment of that person's mental capacity. The assessment follows the two-step assessment process recommended in the Mental Capacity Act 2005's Code of Practice.' However, we found the policy was not followed in practice. For example, three people were described in their care plan as having 'limited capacity' but there was no assessment of the person's capacity, or their ability to make decisions relating to the care provided. For example, one person had arrangements in place to restrict access to their medication. There was no capacity assessment for their agreement to this or information about a decision made in their best interests.
• Another person's care plan stated they had limited capacity and would require their family to be involved in 'important decisions.' There was no information about the decisions the person would require assistance with. A family member was named as the person's 'advocate' but had no evidenced legal authority to make decision on the person's behalf.
• The information about who would be involved in making decisions about people's care was found to be confusing in other care plans we viewed. People's relatives were referred to as their 'Advocate'. It was not clear how this term was being used and whether the person had made the decision for their views and wishes to be represented by that person.
• A person's care plan stated they had an advocate with Lasting Power of Attorney (LPOA), however there was no evidence to show that this person had the legal authority to make decisions on the person's behalf. We asked the registered manager about this who said they had requested evidence but this had not been supplied. This meant people could be at risk of decisions made by people without the legal authority to do so.
• A person's relative told us they had a LPOA for health and welfare and financial decisions. However, the person's care plan did not include this information. The relative told us they had not been consulted about the person's care plan and had not been asked for any involvement in decisions. This meant people could be at risk of having decisions made without the involvement of their legal representatives.
• Care staff we spoke with had limited knowledge of the mental capacity act and how they used the principles of the act when supporting people. This included the registered manager who said they had now realised they needed to carry out assessments and had started to do this.
• An 'Informed Consent' document was in place. This confirmed the person's consent to their care and treatment, information sharing and the taking of a photograph. However, this document was not consistently signed. The form stated that if the person could not sign then the person 'responsible for them' should sign. In one person's care plan there was no information about who helped them to make decisions, or had the legal responsibility to do so but the consent form stated it should be signed by their daughter. The arrangements in place to ensure care and treatment was provided with the consent of the relevant person were not clear or lawful.

• The failure to ensure care and treatment was provided with the consent of the relevant person and in accordance with the Mental Capacity Act 2005 is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Care and support did not reflect current evidence based-guidance, standards and practice. For example; NICE guidance for 'Managing medicines for adults receiving social care in the community' was not followed regarding the management of people's medicines and staff competency. Staff were not encouraged to follow best practice. Skills for Care guidance was not followed in relation to staff training and induction. People were not supported in line with the Mental Capacity Act (2005).

Supporting people to eat and drink enough to maintain a balanced diet
• People told us they received the support they needed with food and drinks. One person told us that staff encouraged them to eat and drink and this was appreciated by them. Despite this feedback, risk assessments were not in place to identify and mitigate risks to people from malnutrition or dehydration, we have referred to these concerns in the 'Safe' Domain of this report.

Supporting people to live healthier lives, access healthcare services and support to provide consistent, effective, timely care
• People and their relatives told us that staff had identified healthcare needs which enabled them to get treatment. For example; a person's relative told us that the registered manager had "Flagged up an infection which prompted us to contact someone straight away."
• We saw that concerns about people's health had been recorded in people's daily notes, however we could not see the actions taken and any outcome of these actions as they were not recorded in people's care plans. We spoke to a staff member who said they had taken action such as contacting the GP and district nurses but had not recorded this. This was important to ensure people's health concerns could be monitored for progress and to prevent any deterioration in their health. This information ensures any recommendations made by other healthcare professionals can be known by staff and carried out as directed.

Requires Improvement

# Is the service caring?

## Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; equality and diversity
• People were mostly positive about the caring attitude of staff, we received some feedback which described some staff as 'Inexperienced' and one person said "Caring? Most of them are." Other people's comments included "(Registered manager) is particularly observant and helpful, she has a routine which is very important to me." A person said "Caring? Yes, I would say pretty caring tied in with the fact that I am helpful." Another person said, "They are caring, they don't rush me they wait for me even though I'm slow because I would rather do as much as I can for myself."
• A person and two relatives told us they found it difficult to understand a staff member with English as a second language. A person said, "I can't understand them and they can't understand me, when (carer) doesn't understand the language and is not fully trained then it is very awkward." We spoke to the registered manager about this who said this carer was no longer working alone whilst they achieved improvements in their English language speaking skills.
• People's care plans included information about people's spiritual needs, however care plans did not consider people's needs in relation to any of the other protected characteristics under the Equalities Act 2010 had been identified or assessed.
• Some people's relatives told us they were very appreciative of the flexibility the registered manager had offered which meant they could have their preferred care arrangements.

Supporting people to express their views and be involved in making decisions about their care
• People were not always supported in line with their preference for the gender of care staff. We were told by a person's relative that they (person) would prefer a female carer and they said, "If it was a male carer (person) wouldn't let him wash her." However, they said male carers supported the person and this person could refuse personal care. The person's care plan did say they preferred a female carer. In two people's care plans we noted that people had stated their preference for the gender of their carer, but then the 'no preference' box had been ticked. Both these people were assessed as having 'limited or diminished mental capacity'. People's views were not always supported and respected when expressed.
• People we spoke with told us staff did listen to them and respected their decisions. One person's relative told us staff listened to them, another person's relatives told us they were not consulted about the person's care and this person had a cognitive impairment. From the information we received from the person's relatives and the information available in the person's care plan it was not evident the registered manager had gathered sufficient information to identify and understand the person's preferences and views, including the views of their relatives and legal representative.

Respecting and promoting people's privacy, dignity and independence
• People told us they were treated with dignity and respect. Staff we spoke with described how they provided

care to promote people's dignity for example; a staff member said, "I would always ask other people to step outside, pull the curtains and shut the door, I'm very aware of that."

Inadequate

# Is the service responsive?

## Our findings

Responsive – this means we looked for evidence that the service met people's needs

Services were not planned in ways that met people's needs. Some regulations were not met.

End of life care and support
• One person had a condition which was life limiting. However, they did not have a care plan or risk assessment in place to assess and manage their needs in relation to their end of life care needs, including pain relief. Staff had not completed training in end of life care to ensure they were aware of national good practice guidance and how to provide care in line with this. Staff providing care had not completed training or had their competency checked in aspects of care they were delivering to the person such as administration of medicines, including those prescribed as required for pain relief, or the safe moving and handling of the person. The service had worked with the person's family to ensure they could be cared for by the carer of their choice.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People's care plans were completed at the time of their initial needs assessment. The care plans we reviewed at the start of our inspection showed they had not always been completed with people's up to date information about their care and treatment. Whilst the registered manager made changes to some people's care plans during our inspection, the service did not have a robust system to ensure care planning was embedded to accurately reflect how people's care and treatment needs had changed and guide staff on the up to date and accurate delivery of their care and treatment needs.
• It was not clear that people always received care and treatment in line with their care plans. The information we were given about people's care from the registered manager and the information in people's care plans was contradictory. For example, one person's care plan stated they should be supported to move using a hoist by trained and competent staff only. We were told by the registered manager that staff did not support people using a hoist because staff had not been sufficiently trained or checked as competent to do so. However, we were told by a relative and staff member that staff did support a person using a hoist and daily records confirmed this. The registered manager told us their care plan should be updated to say a hoist was not to be used.
• Care plans lacked person-centred information about people's needs to guide staff as to how people preferred to be supported. The care plan of a person living with dementia, who required encouragement with their personal care stated staff to 'make sure' the person had a wash. There was no supporting information to guide staff as to how the person preferred to be supported to meet their personal hygiene needs. Some information in people's care plans appeared to be incorrect for example; a person's care plan said they had 'severe dementia' the care plan lacked any information about the person's communication needs. The registered manager said the person was fully able to communicate their needs and wishes and the dementia was not severe.
• A person's relatives told us they had not been consulted about their relative's care plan "We've never been asked about their history, family life etc". This person's care plan stated that 'nothing provided by the service user' in response to 'what is important for you to know about my past'. This person's relatives were

concerned they were not always receiving the care they needed and although a discussion with the registered manager had identified concerns and changes required to the plan of care these had not been implemented.
• The failure to assess, plan and provide care and support that met people's needs and preferences was a breach of Regulation 9 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns
• People and relatives knew how to complain but were not all confident that their concerns would be listened to or acted on. A person's relative said, "I wouldn't be confident enough to rock the boat". Although they had raised concerns about the care delivered they had felt the response was not "truthful or satisfactory." The changes agreed as an outcome of these concerns had not been acted on and the person said, "I think they just made an excuse and covered up."
• We viewed the complaints file and saw this contained two complaints received in November and December 2018. Both complaints concerned unsafe moving and handling incidents. The response to these complaints demonstrated they had not been properly investigated or appropriately acted upon in a timely manner. For example, in response to the concerns raised by a healthcare professional about unsafe moving and handling received on 20 December 2018, the care staff concerned had been booked onto refresher training on the 19 January 2019. From the record of the response there was no evidence that an investigation had taken place which considered whether a referral to the local authority safeguarding team was needed, or whether other immediate actions were required to prevent similar situations. This meant people were exposed to further risks.
• From the information available there was no information about how the complainant had been responded to. We asked the registered manager if they had responded to the complainants and they said, "Not yet".
• The failure to investigate and act on complaints received and to establish and operate an effective system for recording handling and responding to complaints was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

There were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff.

• The registered manager did not have effective systems in place for identifying and managing risks to the quality of the service. The registered manager told us they had initially delegated the day to day running of the service in August 2018 to an unregistered person who was a director of the company. Following concerns raised about the treatment of a person by staff the registered manager became aware of serious shortfalls in the quality and safety of the service; including the unsafe recruitment of staff, the management of the business and the training and competency of staff delivering care. The registered manager told us they had been "Too trusting" of the delegated person. There was a lack of effective systems and processes to promptly identify that the quality and safety of the service were being compromised and people had received unsafe care and treatment.

• The registered manager had produced an action plan in response to concerns raised by the Local Authority in a letter dated 24 January 2019. The registered manager told us this was the improvement action plan in place for the service. The action plan had not identified all the concerns we found and did not include actions in relation to safe recruitment and the application of the Mental Capacity Act (2005). The action plan was not sufficiently detailed to show what action would be taken by whom and by when. For example, although the registered manager stated, 'all MAR charts will be audited every month' MAR charts were not in place at the time of our inspection. The action plan did not give sufficient detail about when the improvements to people's care plans, risk assessments and the skills, knowledge and competency of staff would be achieved. We were not assured the action plan was sufficiently robust or timely to enable the registered manager to make and monitor the improvements required to the service.

• Regulatory requirements were not understood or met. We found eight breaches of Regulation during our inspection. An effective system was not in place to assess and monitor the service against the Regulations, this meant people were at risk of unsafe care and treatment.

• A quality assurance system was not in place to seek the view of people, their relatives and other stakeholders about the quality of the service. We asked the registered manager about this who told us they would ask people during a review. The registered manager showed us one completed review which did not include any feedback about the service. People and their relatives we spoke with confirmed they had not been asked for their views on the service.

• The failure to ensure an effective system to assess, monitor and mitigate risks to the service and improve the quality and safety of the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• CQC require registered persons to notify us of significant events that occur in the service. These are incidents that enable CQC to monitor the service and analyse any risks that might be arising. We identified

two incidents which should have been notified to us. These incidents related to a safeguarding allegation and an event that threatened the registered manager's ability to continue to carry on the regulated activity safely.
• The failure to notify the CQC was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009

Working in partnership with others; Continuous learning and improving care
• Following concerns about the quality and safety of the service a team manager from the Local Authority told us they, and colleagues had met with the registered manager on five occasions to offer support and guidance in making improvements to the service. However, the registered manager had failed to make prompt improvements. The company secretary told us "(The local authority) offered a lot but we were busy delivering care rather than taking on training". There was a failure to take prompt action to address issues of concern when raised by a stakeholder.

Planning and promoting person-centred, high-quality care and support;
• The service did not have a coherent strategy based on realistic objectives. The registered manager and company secretary were working as carers. There was little time to attend to the governance of the service and ensure systems were in place to support the delivery of high quality care and support. The registered manager was unable to provide us with a fully completed rota showing which staff worked where and when. A staff member said, "Scheduling is a problem - no fixed rota you only know a day or two before so not a plan for the week."
• Whilst policies and procedures were available to guide staff on delivering care such as; Mental Capacity Act (2005) and medication policy these policies were not carried out in practice. A staff member told us they had read the safeguarding and whistleblowing policies only. There was no system to check staff had read policies and procedures. The registered manager told us staff could request a policy by email, or they were available on the office computer. Policies such as the recruitment and selection policy were not followed in practice. The checks and references outlined in the policy were not obtained for new staff. This meant policies and procedures were not fully embedded to ensure they were followed or understood by all staff to underpin high quality care and support.
• People's records were not always up to date and accurate. For example; records did not include full details of people's prescribed medication or accurately reflect the support they required with their medication. Information in consent records and mental capacity needs assessments was inconsistent and not accurate. People's care plans were not updated with their changed needs such as following a fall and care plans did not always include details about people's health conditions and treatment.
• The failure to maintain an accurate, complete and up to date records in respect of each person was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
• The registered manager and company secretary showed a willingness to learn from shortfalls in the quality and safety of the service identified during the inspection and take action to achieve the improvements required.